State of Rhode Island
Department of Labor and Training
Division of Workers' Compensation
1511 Pontiac Avenue
Cranston, RI 02920

Forms Revised January, 2003

Form Number	Form Title
DWC-01	Employer's First Report of Alleged Occupational Injury or Disease
DWC-02	Memorandum of Agreement
DWC-03F	Wage Statement, Full Time
DWC-03P	Wage Statement, Part-Time
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State of Rhode Island
Department of Labor and Training
Division of Workers' Compensation
1511 Pontiac Avenue
Cranston, RI 02920

Forms Revised January, 2003

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State of Rhode Island

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942
Phone (401) 462-8100 TDD (401) 462-8006 FAX (401) 462-8105

DWC No. _____

Insurer File No.

1. EMPLOYER LOCATION:	**2. EMPLOYER NAMED ON WC INSURANCE POLICY:** ☐ **SAME AS BLOCK 1**
FEIN	FEIN
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Ext. Type of Business	Phone Ext.
RI Unemployment Ins. No. NAICS	WC Policy Number

3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.

5. EMPLOYEE INFORMATION:		**6. MEDICAL INFORMATION:**
SSN ☐ Male ☐ Female		Treatment Facility
Name		Address
Address		City, State, Zip
City, State, Zip		Phone Ext.
Phone	Date of Birth	**7. WITNESS INFORMATION:**
Occupation	Date Hired	Name Phone
State of Hire	Preferred Language of Employee: O English O Spanish O Portuguese O Other:	

8. INJURY INFORMATION:	What was person doing when injured?
Injury Date	
Time injury occurred ☐ AM ☐ PM	
Time employee began work ☐ AM ☐ PM	
1. First full day lost from work ☐ NONE LOST	
2. Date returned to work (if appropriate)	List injured body parts and nature of injury:(ex: Broken left finger, lower back strain)
3. Date employer notified of injury	
If fatal - **REPORT WITHIN 48 HOURS** - Date of death	
Place where injury/illness occurred: ☐ At employer location listed in Block 1 **OR**	Complete address where accident occurred:
Was this injury previously an incident-only with no medical treatment and no time lost? ☐ Yes ☐ No	
If Yes, date employer first notified of medical treatment or time lost	
Category(ies) of injury or illness: O Injury O Illness O Occupational Disease O Repetitive Trauma O Occupational Hearing Loss O Unknown	

Print Name of Report Preparer	Date Prepared	Phone & Extension
Print Name of Employer Contact Person OR ☐ Same as above		Phone & Extension

DWC:	County	Time A	Time W	OCC	Nature	Part	Source	Type	

EMPLOYER'S FIRST REPORT OF ALLEGED OCCUPATIONAL INJURY, DISEASE OR FATALITY (DWC-01)

By law, the employer must complete a First Report of Injury for an employee for any work-related injury, if that injury requires any medical treatment or if the employee loses full wages for at least three (3) days. The employer must also report any work-related death.

General Instructions:

- Please clearly print or type information into all of the areas of the First Report – FORMS MAY BE REJECTED IF INCOMPLETE.
- Completed by: Employer.
- Time Frame: Within 10 days of knowledge of the injury OR within 48 hours of death. If you do not send in the First Report on time **or** if it is incomplete, you may be subject to a **$250 fine**.
- Distribution: Original to Department of Labor and Training (DLT)/address on form; Copy to Claim Administrator; Employer File Copy.
- Attachments: None. DO NOT ATTACH MEDICAL REPORTS.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. ***Employer Location:***
   - *FEIN:* Employer's Federal Employer Identification Number.
   - *Name:* Employer's actual name where the employee was employed at the time of the injury.
   - *Address (including city, state, zip):* Address of the employer's actual location.
   - *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.
   - *Type of Business:* General classification of what the business does on a daily basis. (Ex. Restaurant; Jewelry Manufacturing; etc.)
   - *RI Unemployment Ins. No.:* This number (ERN – Employer Record Number) is assigned to employers by the Rhode Island Division of Taxation and is used by employers when paying their RI Unemployment Insurance and Temporary Disability Insurance taxes. The Division of Worker's Compensation will use this number for employer identification purposes only.
   - *NAICS:* North American Industry Classification System, established by the US Census Bureau to provide common industry classifications based on the type of business. Visit www.census.gov and click on NAICS to locate the industry code. IF THIS CODE CANNOT BE OBTAINED, BE SURE TO HAVE COMPLETED 'Type of business' on the form.
2. ***Employer Named on WC Insurance Policy:*** If this information is identical to the information in Block 1, check the 'Same' box, complete the WC Policy information, and move onto Block 3. If different, proceed below.
   - *FEIN:* Federal Employer Identification Number of the employer listed on the WC Insurance Policy.
   - *Name:* Insured named on the policy or the financially responsible self-insured employer, as certified by DLT.
   - *Address (including city, state, zip):* Mailing address of the employer named on the WC Insurance Policy.
   - *Phone/Ext:* Phone number and extension (if necessary) of the named employer's facility.
   - *WC Policy Number:* Number assigned to the WC contract or policy for that employer.
3. ***Insurance company named on WC Policy:***
   - *FEIN:* WC Insurance company's Federal Employer Identification Number.
   - *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
   - *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
   - *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
4. ***Claim Administrator****:* If this information is identical to the information in Block 3, check the 'Same' box, and move onto Block 5. If different, proceed below.
   - *FEIN:* Federal Employer Identification Number of the company administering the claim.
   - *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
   - *Address (including city, state, zip):* Mailing address of the claim administrator.
   - *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
5. ***Employee:***
   - *SSN:* Employee's Social Security Number.
   - *Male/Female:* Check one.
   - *Name:* Employee's full name as shown on payroll.
   - *Address (including city, state, zip):* Employee's current mailing address.
   - *Phone:* Employee's current home telephone number.
   - *Date of Birth:* Date the employee was born.
   - *Occupation:* Primary occupation of the employee at the time of the accident.
   - *Date Hired:* Date the employee began his or her employment with the employer.
   - *State of Hire:* State in which the employee was actually hired.
   - *Preferred Language of Employee:* Primary language spoken or understood by the employee.
6. ***Medical Information:***
   - *Treatment Facility:* Name of the facility where employee received treatment for injury or illness.
   - *Address (including city, state, zip):* Treatment facility address.
   - *Phone/Ext:* Phone number and extension (if necessary) of the treatment facility.
7. ***Witness Information:***
   - *Name:* Name of person or persons who witnessed injury.
   - *Phone:* Phone number (s) of witness(es)

8. Injury Information:

- *Injury Date:* Date that the accident happened.
- *Time injury occurred:* Time that the injury happened.
- *Time employee began work:* Time that the employee began work on the day the injury happened.
- *First full day lost from work:* First full day that the employee lost from work (include weekends and holidays). This is referred to as the Incapacity Date throughout the claim OR check *NONE LOST* if the employee lost no time due to the injury.
- *Date returned to work (if appropriate):* If employee has returned to work, complete this question.
- *Date employer notified of injury:* Date that the injury was reported to a representative of the employer.
- *If fatal, REPORT WITHIN 48 HOURS – Date of Death:* Conditional, if employee died.
- *What was person doing when injured:* A brief description of how the accident happened.
- *List injured body parts and nature of injury:* Detailed description of what part or parts were injured and what type of injury it is.
- *Place where injury/illness occurred:* Check box if the injury happened at the address of the employer listed in Block 1 OR enter the complete address (including city and state) where injury actually took place.
- *Was this injury previously an incident-only with no medical treatment and no time lost?:* Check *No* if that is the appropriate answer. Checking *Yes* refers to injuries which were originally not reportable to the State—meaning that the employee lost no time or received no medical treatment for their injury (incident only). If the injury later becomes reportable because the employee now has **either** lost full wages for at least three (3) days **or** received any medical treatment due to the work-related injury, then check Yes.
- *If Yes, date employer first notified of medical treatment or time lost:* If *Yes* was checked, enter appropriate date.
- *Category(ies) of injury or illness:* Check the appropriate item(s).

- *Print Name of Report Preparer/Date Prepared/Phone & Extension:* Clearly enter the name of the person who filled out the form, the date that the form was prepared, and the complete phone number of the preparer.
- *Print Name of Employer Contact Person OR Same as above /Phone & Extension:* Check box if the information is identical or clearly enter the name and complete phone number of the employer's contact person.

State of Rhode Island
MEMORANDUM OF AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No.

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☐ Temporary Partial as of _____

☐ Death Benefits/Date of Death _____

Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____

AWW (include bonus/no OT) _____

Average Overtime Amount _____

AWW including Overtime _____

Spendable Base Wage _____

Base Compensation Rate _____

Number of Dependents _____

Weekly Dependency Rate _____

Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT UNDER MOA: _____

Does employee have other employers? ☐ Yes ☐ No If yes, attach a wage statement from each employer.

Is this a recurrence of a previous injury? ☐ Yes ☐ No Previous disability end date: _____

Has the employee worked at least 26 weeks prior to this recurrence? ☐ Yes ☐ No If yes, a new wage statement is required.

Signature: Date:

Print Name: RI Adjuster License Number: Phone & Extension:

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:

YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

MEMORANDUM OF AGREEMENT
(DWC-02)

General Instructions:

- Completed by: Claim Administrator.
- Time Frame: No set time frame. However, an MOA will be expected if payments made under a Non-Prejudicial Agreement go beyond 13 weeks. The MOA must be filed with the Department of Labor and Training (DLT) within 10 days of initial payment.
- Distribution: Original to DLT. Copy to the employee and his or her attorney by certified mail or sent with compensation check.
- Attachments: A wage statement for each employer and a dependency form (unless both were attached to Non-Prejudicial Agreement) and a Report of Indemnity Payment (DWC-22).

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

2. Employer:
- *FEIN:* Employer's Federal Employer Identification Number.
- *Name:* Employer's actual name where the employee was employed at the time of the injury.
- *Address (including city, state, zip):* Address of the employer's actual location.
- *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.

3. Insurance company named on WC Policy:
- *FEIN:* WC Insurance company's Federal Employer Identification Number.
- *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
- *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
- *RI License Number:* License number issued by the RI Department of Business Regulation (DBR).

4. Claim Administrator*:* If this information is identical to the information in Block 3, check the 'Same' box. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
- *RI License or Self-Insurance Number:* License number issued by DBR or Self-Insurance Certificate number issued by DLT.
- *Injury date:* Date that the accident happened.
- *First date of first disability:* First full day that the employee lost from work during the first period of disability for the injury.
- *Place where injury occurred:* City and State where injury took place.

5. Disability Type:
- Check the appropriate box(es) and enter incapacity date or appropriate start date. Do **not** adjust date for three-day waiting period.
- *Death Benefits/Date of Death – Payable to:* Date of death and name of eligible dependent to whom payment shall be made.

6. Rate Information:
- *Single/Married:* Check one.
- *Number of Exemptions:* Enter figure from *Total Number of Exemptions* box on Dependency form (DWC-04).
- *AWW (include bonus/no OT):* Enter average weekly wage that contains the averaged bonus amount, but not overtime (line 5 under *Calculation of AWW* on the full or part-time wage statements). Note: Adjust amounts throughout for multiple wage statements.
- *Average Overtime Amount:* Enter averaged overtime figure (line 6 under *Calculation of AWW* on the full or part-time wage statements).
- *AWW including Overtime:* Enter total average weekly wage (line 7 under *Calculation of AWW* on the full or part-time wage statements).
- *Spendable Base Wage:* Enter appropriate figure from Gross Wage to Spendable Earnings Table.
- *Base Compensation Rate:* Base compensation rate is 75 percent of the Spendable Base Wage, up to the maximum rate.
- *Number of Dependents:* Enter total number of dependents (not exemptions). Include **non-working** spouse.
- *Weekly Dependency Rate:* **Total Incapacity Only**. $15 per dependent or $40 per dependent for death claim.
- *Total Weekly Rate:* Enter total weekly compensation rate. Note: Compensation rate plus dependency rate cannot exceed 80 percent of the total average weekly wage. Difference should show against the dependency rate on the Agreement.

7. Date of Initial Payment:
- Enter the date of the first payment made under the Memorandum of Agreement.
- *Other Employers/Recurrence* block: Complete and attach appropriate information, if necessary.
- *Signature/Date:* Signature of the person who filled out the form and the date that the form was prepared.
- *Print Name/RI Adjuster License Number/Phone & Extension:* Clearly enter the name of the person who filled out the form, their RI Adjuster License Number as issued by the RI Department of Business Regulation, and the complete phone number of the preparer. Note: DO NOT ENTER SSN – Request another number from DBR.

State of Rhode Island
FULL-TIME WAGE STATEMENT (Hired for 20 hours or more per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN _____
Name _____
Hired for_____ hours each week (☐ Approximate)
Are these supplemental wages? ☐ Yes ☐ No
If yes, supplemental employer name: _____
Maximum no. of exemptions_____ ☐ Single ☐ Married

CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Hire date _____

EMPLOYED LESS THAN 2 WEEKS:

If Yes:	**OR:**
1. List agreed upon hourly wage _____	
2. Number of hrs. per week for full-time employees _____	Give average weekly for same or similar employment: _____
3. Multiply #1 by #2 for average weekly wage	

EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS.** Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 13 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 13 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name: Date:	Print Adjuster Name: Date:

FULL-TIME/PART-TIME WAGE STATEMENTS
(DWC-03F/DWC-03P)

General Instructions:

- Full-time: Hired for 20 hours or more per week. (13 weeks of wages)
- Part-time: Hired for less than 20 hours per week. (26 weeks of wages)
- Completed by: Employer.
- Time Frame: No set time frame. However, the wage statement should be completed as soon as the employee has been out of work for four consecutive days due to his or her work-related injury.
- Distribution: Original from employer to claim administrator. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Hired for:* Number of hours that the employee was hired to work per week. Check box if hours are not regularly scheduled but approximated.
- *Are these supplemental wages? Yes/No:* Check No if the wages are from the employer where the employee was injured. Check Yes if the employee has more than one employer and the wage statement is from the employer where the injury did not occur.
- *If Yes, supplemental employer name:* Name of the supplemental employer.
- *Maximum no. of exemptions/Single or Married:* Total exemptions the employee is able to claim; **not** necessarily what is on the employee's W-4 form. Check appropriate marital status.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Hire Date:* Date the employee began his or her employment with the employer.

3. Employed Less Than 2 Weeks: Use this section **only** if the employee was employed for less than two full weeks.

- *List agreed upon hourly wage:* Hourly rate of pay agreed to between employer and employee.
- *Number of hrs. per week for full-time (part-time) employees:* Enter number of hours full-time (part-time) employees are generally scheduled for the employer.
- *Multiply #1 by #2:* Multiply the hourly rate by the number of scheduled hours for the average weekly wage (AWW).
- *OR Give average weekly for same or similar employment:* If no hourly rate was agreed upon, put the AWW for the same or similar job.

4. Employed More Than 2 Weeks: Follow the instructions.

- *LIST 13 (26)* ***CONSECUTIVE*** *WEEKS:*
  - *Week Ending Date:* Ending date of the weekly earnings period.
  - *No. of standard hours worked:* Number of hours worked for the week listed.
  - *Gross Wages (No Overtime):* Gross wage for the week listed. Include Sunday and Holiday pay. Do not include overtime.
  - *Total number usable weeks:* Total the number of weeks listed that have wages entered.
  - *Total Earnings:* Total of wages entered.
- *BONUS AND OVERTIME CALCULATION:*
  - *Number of weeks employed(up to 52):* Number of weeks the employee had been employed prior incapacity date. If more than 52, enter 52.
  - *Total BONUS amount paid in past 52 weeks:* Total of all bonus monies paid to employee in 52 weeks prior to incapacity date.
  - *Divide Block 2 by Block 1 for average bonus:* Divide total bonus monies by number of weeks employed (up to 52).
  - *Total OVERTIME amount paid in past 52 weeks:* Total of all overtime monies paid to employee in 52 weeks prior to incapacity date.
  - *Divide Block 4 by Block 1 for average overtime:* Divide total overtime monies by number of weeks employed (up to 52).
- *CALCULATION OF AVERAGE WEEKLY WAGE(AWW):*
  - *1. Total earnings from 13 (26) weeks:* Enter the total earnings from the left side of the wage statement.
  - *2. Total number usable weeks:* Enter the total the number of usable weeks from the left side of the wage statement.
  - *3. Divide total earnings by number of usable weeks:* Enter calculation.
  - *4. Average bonus:* Enter the calculation from Block 3 above.
  - *5. Add 3 and 4 for AWW excluding Overtime:* Enter calculation.
  - *6. Average overtime:* Enter calculation from Block 5 above.
  - *7. Add 5 and 6 for Total Average Weekly Wage:* Enter calculation.
- *Print Preparer Name/Date:* Clearly enter the name of the person who filled out the form and the date that the form was prepared.
- *Print Adjuster Name/Date:* Clearly enter the name of the adjuster who checked the calculations on the form and the date signed.
- More wage calculation tips.

WAGE CALCULATION TIPS

When a wage statement arrives at DLT, Division of Workers' Compensation from the claim administrator, each one is calculated separately to ensure accuracy. If incorrect, a letter is sent to the claim administrator who must contact the employer to get the corrections; the corrections go back to the claim administrator and again are sent to DLT. To avoid this lengthy process and promote prompt payment to the injured worker, please review these tips.

- Be ready to prepare a wage statement as soon as the employee has been out of work for 4 calendar days. A delay in completing the wage statement can lead to problems with a claim.
- Know which wage statement to use and have it available. Do not wait for the claim administrator to send you the wage statement. Use the…
  - Full-time for a person hired for 20 hours or more per week.
  - Part-time for a person hired for less than 20 hours per week.
  - Seasonal for a person hired to work for 16 weeks or less.
- The same rules for completion apply to the full-time and the part-time wage statements. The seasonal wage statement is different (see Seasonal Wage Statement instructions).
- Complete all areas of the wage statement – you may not realize the many uses for a single number or date.
- Be sure to include the number of hours per week the employee was hired to work.
- Injury date and Incapacity date are very important. Incapacity date is the first full calendar day that the employee was out of work due to their injury.
- Hire date must be provided – it is used for several reasons.
- Use the correct section depending on whether the employee worked less or more than 2 weeks.
- USE CONSECUTIVE WEEKS ALWAYS – whether the employee earned money or not.
- COMPLETE ALL COLUMNS. Skipping weeks and incomplete columns are two troublesome errors.
- Weeks go backwards from the incapacity date – not the injury date.
  - EX: Injury date: 5/10/2003; Incapacity date: 8/13/2003. Wages would go from 8/13/2003 back 13 or 26 weeks (depending on the statement used).
- In this same example, you would not use the week of incapacity unless it was a full week worked.
  - EX: If the employee was hired for 40 hours and worked 40 hours during the week of the incapacity, that week could be used on the wage statement. If the employee worked less than the 40 hours, you would not list the week, but would start with the week previous (no matter how many hours worked that week).
  - The same rule applies for the week of hire if it appears on the wage statement, only use it if a full week was worked.
- No overtime or bonus monies or hours should be listed in the 13 (26) weeks. They are calculated separately on the right side of the form.
- Since overtime is generally paid after 40 hours, if an employee worked more than 40 hours without earning any overtime, use the total hours and put *NO OT* next to the hours. This will let others know that, although more than 40 hours are listed, no overtime is included.
- Common examples of what <u>will be</u> included in the 13 (26) weeks:
  - Commissions
  - Holiday Pay - except during an unpaid plant shutdown week
  - Shift Differential
  - Sick Pay or put "UNPAID"
  - Sunday Pay
  - Vacation Pay or put "UNPAID"
- Sick and vacation pay are included, but if the employee did not receive payment for any of those weeks which might appear, put the word "UNPAID" in the Gross Wages column instead of a zero. This will let others know that it was, in fact, unpaid. Otherwise, one might think that the preparer did not know that those monies are used.
- When determining *Total number of usable weeks*, add up only the weeks where wages are listed. Zero weeks are not used in the mathematical computation when getting the average weekly wage (AWW).
- Although only 13 or 26 weeks of wages are used, you must go back 52 weeks from the incapacity date to collect bonus and overtime monies.
- In *Block 1*of the Bonus and Overtime Calculation, remember to only use the number of weeks employed up to 52. If the employee worked for less than 52, list the actual number – if greater than 52, list 52.
- Following the step-by step instructions on the remainder on the wage statement should result in an accurate computation of the AWW.
- Many unique circumstances may develop when completing a wage statement, contact your WC claim administrator or call a DLT Claims Analyst at (401) 462-8120 for help.
- All wage statements are available in an Excel format, which will do the final calculations for you!

State of Rhode Island
PART-TIME WAGE STATEMENT (Hired for less than 20 hours per week)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

EMPLOYEE INFORMATION:

SSN _____
Name _____
Hired for_____ hours each week (☐ Approximate)
Are these supplemental wages? ☐ Yes ☐ No
If yes, name of supplemental employer _____
Maximum no. of exemptions_____ ☐ Single ☐ Married

CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Hire date _____

EMPLOYED LESS THAN 2 WEEKS:

If Yes:	**OR:**
1. List agreed upon hourly wage _____	
2. Number of hrs. per week for part-time employees _____	Give average weekly for same or similar employment: _____
3. Multiply #1 by #2 for average weekly wage	

EMPLOYED MORE THAN 2 WEEKS:

On the left side of the form, list gross wages prior to employee's first full day out of work. **DO NOT** include their week of hire or week of injury *unless* a full week was paid. **DO NOT SKIP WEEKS**. Please calculate any overtime and/or bonus paid **SEPARATELY** on the right side of the form below.

LIST 26 **CONSECUTIVE** WEEKS:

Week Number	Week Ending Date	No. of standard hrs. worked	Gross Wages (No Overtime)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
Total number usable weeks:		Total earnings:	

BONUS AND OVERTIME CALCULATION:

Number of weeks employed (up to 52)	Block 1
Total **BONUS amount paid** in past **52 weeks**	Block 2
Divide Block 2 by Block 1 for average bonus	Block 3
Total **OVERTIME amount paid** in past **52 weeks**	Block 4
Divide Block 4 by Block 1 for average overtime	Block 5

CALCULATION OF AVERAGE WEEKLY WAGE (AWW):

1. Total earnings from 26 weeks	
2. Total number usable weeks	
3. Divide total earnings by number of usable weeks	
4. Average bonus (Block 3 in BONUS AND OT)	
5. Add 3 and 4 for AWW excluding Overtime	$
6. Average overtime (Block 5 in BONUS AND OT)	
7. Add 5 and 6 for Total Average Weekly Wage	$

Print Preparer Name: Date:	Print Adjuster Name: Date:

DWC-03P (01/03)

For instructions visit our web site: www.dlt.ri.gov/wc

State of Rhode Island
SEASONAL WAGE STATEMENT (Hired for 16 weeks or less)

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____

Name _____

Maximum no. of exemptions_____ ☐ Single ☐ Married

Wages for how many employers are listed below? _____

2. CLAIM INFORMATION:

Employer _____

Insurance Co. _____

Claim Administrator _____

Injury date _____

Incapacity date _____

Hire date _____

List 52 CONSECUTIVE weeks of gross wages for *any* employment held by this person within the 52 week period.

Week Number	Week Ending Date	Gross Wages	Week Number	Week Ending Date	Gross Wages
1			27		
2			28		
3			29		
4			30		
5			31		
6			32		
7			33		
8			34		
9			35		
10			36		
11			37		
12			38		
13			39		
14			40		
15			41		
16			42		
17			43		
18			44		
19			45		
20			46		
21			47		
22			48		
23			49		
24			50		
25			51		
26			52		
		Total earnings:			Total earnings:

1. Combine total earnings listed _____
2. Divide total earnings by 52 ÷ 52
3. Average Weekly Wage $ _____

Print Preparer Name: Date:	Print Adjuster Name: Date:

For instructions visit our web site: www.dlt.ri.gov/wc

SEASONAL WAGE STATEMENT
(DWC-03S)

General Instructions:

- Seasonal: Hired for 16 weeks or less (52 weeks of wages) NOTE: Only used when the employee is injured on his or her seasonal job.
- Completed by: Employers/Insurer.
- Time Frame: No set time frame. However, the wage statement should be completed as soon as the employee has been out of work for four consecutive days due to his or her work-related injury.
- Distribution: Original from employer to claim administrator. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Maximum no. of exemptions/Single or Married:* Total exemptions the employee is able to claim; **not** necessarily what is on the employee's W-4 form. Check appropriate marital status.
- *Wages for how many employer are listed below?:* Enter total number of separate employers wages are listed for on statement.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Hire Date:* Date the employee began his or her employment with the employer.

- *List 52 CONSECUTIVE weeks of gross wages for any employment held by this person within the 52 period:*
  - *Week Ending Date:* Ending date of the weekly earnings period.
  - *Gross Wages:* Gross wage for the week listed. Include all earnings (Sunday, Holiday, Overtime, etc).
  - *Total Earnings:* Total of wages entered for each column.

  - *1. Combine total earnings listed:* Enter the total earnings from both columns.
  - *2. Divide total earnings by 52:* Do the math.
  - *3. Average Weekly Wage:* Enter calculation.

- *Print Preparer Name/Date:* Clearly enter the name of the person who filled out the form and the date that the form was prepared.
- *Print Adjuster Name/Date:* Clearly enter the name of the adjuster who checked the calculations on the form and the date signed.

State of Rhode Island ☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

EMPLOYEE'S CERTIFICATE OF DEPENDENCY STATUS

Department of Labor and Training, Division of Workers' Compensation
Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____ ☐Male ☐Female
Name _____
Address _____
City, State, Zip _____
Phone _____ Date of Birth _____

2. CLAIM INFORMATION:

Employer _____
Claim Administrator _____
Address _____
City, State, Zip _____
Date of Injury _____ Date of Incapacity _____

THE EMPLOYEE MUST COMPLETE ALL REQUIRED INFORMATION:

Please return this form to your employer's workers' compensation Claim Administrator. If they do not receive this completed form promptly, it may result in a delay of your claim.

3. MARITAL STATUS & EXEMPTION INFORMATION: (Needed to calculate your weekly compensation payment)

Were you married at the time of your injury? ☐Yes ☐No If Yes, Spouse Name: _____

If Yes, does your spouse work? ☐Yes ☐No Spouse SSN**: _____

Please put an appropriate number in each box -- you are entitled to one exemption for yourself and one for your spouse.

Yourself	1
Spouse	
Total Dependents Listed **Below**	
Total Other	
Total Number of Exemptions (Add all of the above)	

(**Other**: You may be entitled to additional exemptions if you or your spouse are over 65 or blind. Please contact your employer's workers' compensation Claim Administrator for further information)

4. DEPENDENT INFORMATION List each dependent child below. A dependent child includes:

- ~ Children under the age of eighteen living with you or whom you were required to support at the time of the injury
- ~ Children you support who are over eighteen but who are mentally or physically incapacitated from earning
- ~ Children under the age of twenty-three who are full-time students at an accredited educational facility

Dependent's Name:	Dependent's Date of Birth:	Dependent's Social Security Number:**	If over 18 and under 23, Full-Time Student?	
1.			☐Yes	☐No
2.			☐Yes	☐No
3.			☐Yes	☐No
4.			☐Yes	☐No
5.			☐Yes	☐No
6.			☐Yes	☐No
7.			☐Yes	☐No
8.			☐Yes	☐No
9.			☐Yes	☐No
10.			☐Yes	☐No

Employee Signature: _____ Date: _____

**** Completion of the Social Security Number for Spouse and Dependents is optional.**

Employee Note: **DO NOT return this form to the Department of Labor and Training - RETURN TO Claim Administrator**

EMPLOYEE'S CERTIFICATION OF DEPENDENCY STATUS
(DWC-04)

General Instructions:

- Completed by: Employee.
- Time Frame: No set time frame. However, if the employee does not complete and forward this form to the claim administrator promptly, it may result in a delay of payment.
- Distribution: Original from employee to claim administrator or employer. Claim administrator must attach to appropriate documentation when filing with DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Male/Female:* Check one.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).

3. Marital Status & Exemption Information:

- *Were you married at the time of your injury?:* Check correct box.
- *If Yes, Spouse Name:* First and last name of spouse.
- *If Yes, does your spouse work?:* Check correct box.
- *Spouse SSN:* Completion of the Social Security Number for the spouse is optional.
- *Please put an appropriate number in each box:* Exemption information is used by the claim administrator to calculate the weekly compensation amount. Failure to provide it may result in a delay of payment.
  - *Yourself:* The employee is automatically entitled to one exemption.
  - *Spouse:* Enter '1' in this box if employee is married.
  - *Total Dependents Listed Below:* Add up the number of dependents in Section 4 and put the total in this box.
  - *Total Other:* If employee is entitled to exemptions for over 65 and/or blind, enter number here.
  - *Total Number of Exemptions:* Add above numbers to get total number of exemptions.
- *Dependent's Name:* First and last name of each dependent.
- *Dependent's Date of Birth:* Date each dependent was born.
- *Dependent's Social Security Number:* Completion of the Social Security Number for the dependent is optional.
- *If over 18 and under 23, Full-Time Student?:* For each dependent over the age of 18 and under the age of 23, check box as to whether or not each one is a full-time student at an accredited educational facility.
- *Employee Signature/Date:* Signature of employee and date form was completed.

State of Rhode Island
SUSPENSION AGREEMENT AND RECEIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

We agree that weekly compensation which began on _____(date of incapacity) will end as of _____(date paid through). Payment of medical bills related to this injury may continue. Completing and signing this form does not prevent the employee from claiming future weekly compensation benefits in the event that the employee is unable to work due to this injury.

Employee Signature: Date:

Employer or Insurer Signature: Date:

SUSPENSION AGREEMENT AND RECEIPT
(DWC-05)

General Instructions:

- Completed by: Employer/Insurer and Employee.
- Time Frame: No set time frame. However, the Suspension should be submitted as soon as possible after the end of weekly indemnity payments made under a Memorandum of Agreement (MOA). Claim is not considered closed unless this form is filed with DLT. (See Wage Transcript instructions) NOTE: Do not use a Suspension when payments were only made under a Non-Prejudicial Agreement.
- Distribution: Original to Department of Labor and Training. Copy to each of the parties.
- Attachments: When submitting a *final* Report of Indemnity Payment (DWC-22) under an MOA, a Suspension should be attached.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *We agree that…:* Enter the date of incapacity as defined above and the date that the weekly indemnity payments were made through.
- *Employee Signature/Date – Employer/Insurer Signature/Date:* Both parties must sign and date this form.

State of Rhode Island
NON-PREJUDICIAL AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No.

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number
Injury date:	List injured body parts and nature of injury:
First date of first disability:	
Place where injury occurred:	

5. DISABILITY TYPE: (check all that apply)

☐ Temporary Total as of _____

☐ Temporary Partial as of _____

☐ Death Benefits/Date of Death _____

Payable to: _____

☐ Permanent Total as of _____

6. RATE INFORMATION: ☐ Single ☐ Married

Number of Exemptions _____

AWW (include bonus/no OT) _____

Average Overtime Amount _____

AWW including Overtime _____

Spendable Base Wage _____

Base Compensation Rate _____

Number of Dependents _____

Weekly Dependency Rate _____

Total Weekly Rate _____

7. DATE OF INITIAL PAYMENT: _____

Does employee have other employers? ☐ Yes ☐ No If yes, attach a wage statement from each employer.

Is this a recurrence of a previous injury? ☐ Yes ☐ No Previous disability end date: _____

Has the employee worked at least 26 weeks prior to this recurrence? ☐ Yes ☐ No If yes, a new wage statement is required.

Signature: Date:

Print Name: RI Adjuster License Number: Phone & Extension:

NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION BENEFITS:

YOU MUST REPORT ANY EARNINGS you receive to the Claim Administrator that pays your benefits. Failure to report earnings may subject you to civil or criminal liability. Your endorsement on a benefit check is your statement that you are qualified to receive workers' compensation benefits. You are NOT entitled to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

ATTACH WAGE STATEMENT(S) AND DEPENDENCY FORM

NON-PREJUDICIAL AGREEMENT
(DWC-20)

General Instructions:

- Completed by: Claim Administrator.
- Time Frame: No set time frame for making initial payment. However, once payment is made, a copy of the Non-Prejudicial must be filed with the Department of Labor and Training (DLT) within 10 days.
- Distribution: Original to DLT. Copy to the employee and his or her attorney by certified mail or sent with compensation check.
- Attachments: A wage statement for each employer and a dependency form.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

2. Employer:
- *FEIN:* Employer's Federal Employer Identification Number.
- *Name:* Employer's actual name where the employee was employed at the time of the injury.
- *Address (including city, state, zip):* Address of the employer's actual location.
- *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.

3. Insurance company named on WC Policy:
- *FEIN:* WC Insurance company's Federal Employer Identification Number.
- *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
- *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
- *RI License Number:* License number issued by the RI Department of Business Regulation (DBR).

4. Claim Administrator*:* If this information is identical to the information in Block 3, check the 'Same' box. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
- *RI License or Self-Insurance Number:* License number issued by DBR or Self-Insurance Certificate number issued by DLT.
- *Injury date:* Date that the accident happened.
- *First date of first disability:* First full day that the employee lost from work during the first period of disability for the injury.
- *Place where injury occurred:* City and State where injury took place.

5. Disability Type:
- Check the appropriate box(es) and enter incapacity date or appropriate start date. Do **not** adjust date for three-day waiting period.
- *Death Benefits/Date of Death – Payable to:* Date of death and name of eligible dependent to whom payment shall be made.

6. Rate Information:
- *Single/Married:* Check one.
- *Number of Exemptions:* Enter figure from *Total Number of Exemptions* box on Dependency form (DWC-04).
- *AWW (include bonus/no OT):* Enter average weekly wage that contains the averaged bonus amount, but not overtime (line 5 under *Calculation of AWW* on the full or part-time wage statements). Note: Adjust amounts throughout for multiple wage statements.
- *Average Overtime Amount:* Enter averaged overtime figure (line 6 under *Calculation of AWW* on the full or part-time wage statements).
- *AWW including Overtime:* Enter total average weekly wage (line 7 under *Calculation of AWW* on the full or part-time wage statements).
- *Spendable Base Wage:* Enter appropriate figure from Gross Wage to Spendable Earnings Table.
- *Base Compensation Rate:* Base compensation rate is 75 percent of the Spendable Base Wage, up to the maximum rate.
- *Number of Dependents:* Enter total number of dependents (not exemptions). Include **non-working** spouse.
- *Weekly Dependency Rate:* **Total Incapacity Only**. $15 per dependent or $40 per dependent for death claim.
- *Total Weekly Rate:* Enter total weekly compensation rate. Note: Compensation rate plus dependency rate cannot exceed 80 percent of the total average weekly wage. Difference should show against the dependency rate on the Agreement.

7. Date of Initial Payment:
- Enter the date of the first payment made under the Non-Prejudicial Agreement.
- *Other Employers/Recurrence* block: Complete and attach appropriate information, if necessary.
- *Signature/Date:* Signature of the person who filled out the form and the date that the form was prepared.
- *Print Name/RI Adjuster License Number/Phone & Extension:* Clearly enter the name of the person who filled out the form, their RI Adjuster License Number as issued by the RI Department of Business Regulation, and the complete phone number of the preparer. Note: DO NOT ENTER SSN – Request another number from DBR.

State of Rhode Island
REPORT OF INDEMNITY PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No.

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:	YOU ***MUST*** CHECK ONE OF THE FOLLOWING:
☐ **TERMINATION OF BENEFITS UNDER NON-PREJUDICIAL AGREEMENT***	☐ **INTERIM**
☐ **PAYMENT UNDER MEMO OF AGREEMENT, ORDER OR DECREE**	☐ **FINAL:** Date of last weekly indemnity payment: _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Date of Birth _____
Maximum no. of exemptions _____ ☐ Single ☐ Married

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____
Date of death _____ ☐ NOT work-related

3. RATE INFORMATION:

AWW including Overtime _____ AWW (include bonus/no OT) _____
Spendable Base Wage _____ Total Cost of Living Adjustment(s) _____
Base Compensation Rate _____ Weekly Dependency Rate _____

4. WEEKLY COMPENSATION:

Indicate Payment Type	Payment period Date from	Payment period Date through	Number of Weeks & Days	Total Weekly Rate	Variable Partial Total Spendable	Compensation Paid	☐ Settlement ☐ Deny&Dismiss
☐TI ☐PI ☐DB							Amount:
☐TI ☐PI ☐DB							Decree No.
☐TI ☐PI ☐DB							Decree Date

5. WEEKLY COMPENSATION for Variable Partial Payments: (Complete information above also)

Week Ending	Gross Earnings	Spendable Earnings	Amount Paid	Week Ending	Gross Earnings	Spendable Earnings	Amount Paid

Signature: _____ Date: _____

Print Name: _____ RI Adjuster License Number: _____ Phone & Extension: _____

***THE FOLLOWING NOTICE IS FOR EMPLOYEES TERMINATED UNDER A NON-PREJUDICIAL AGREEMENT ONLY**

Weekly compensation payments have stopped. The insurer/employer has not accepted liability for this claim. If you wish to protect any rights you may have under the Workers' Compensation Act, including possible entitlement to continued or future weekly compensation payments or payment of medical expenses, a petition must be filed with the Workers' Compensation Court within two (2) years from the first date of incapacity.

REPORT OF INDEMNITY PAYMENT
(DWC-22)

General Instructions:

- Completed by: Claim Administrator.

- Time Frame: As a Termination of Benefits under Non-Prejudicial Agreement: Within ten days of the termination of benefits. As a payment under Memorandum of Agreement (MOA): Initial report should be attached to MOA. Additional reports are due every six months on an ongoing claim **or** any time there is any change in the compensation rate (i.e. COLA or change in dependents).

- Distribution: Original to Department of Labor and Training. When used as a Termination of Benefits under Non-Prejudicial Agreement, copies must be sent to employee and his or her attorney within ten days of the termination of payments.

- Attachments: When submitting a *final* payment report under an MOA, a Suspension Agreement and Receipt (DWC-5) should be attached.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.
- *YOU **MUST** CHECK ONE OF THE FOLLOWING:*
  - *Termination of Benefits Under Non-Prejudicial Agreement:* Check only when ending benefits under a Non-Prejudicial Agreement.
  - *Payment under Memo of Agreement, Order or Decree:* Check when appropriate.
- *YOU **MUST** CHECK ONE OF THE FOLLOWING:*
  - *Report type: Final or Interim:* Check *Interim* when weekly indemnity payments will continue. Check *Final* when weekly indemnity payments have ended. Termination of Benefits will always be a *Final*.
  - *If final, date of last weekly indemnity payment:* Enter the date of the last weekly indemnity check.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Date of Death:* Conditional, if employee died – Check box if death was NOT work-related.

3. Rate Information:

- *AWW including Overtime:* Enter appropriate figure as listed on Agreement, Order or Decree.
- *Spendable Base Wage:* Enter appropriate figure as listed on Agreement.
- *Base Compensation Rate:* Enter appropriate figure as listed on Agreement.
- *AWW (include bonus/no OT):* Enter appropriate figure as listed on Agreement.
- *Total Cost of Living Adjustment(s):* If claimant is entitled, enter total cumulative amount calculated for Cost of Living Adjustment.
- *Weekly Dependency Rate:* **Total Incapacity Only**. $15 per dependent or $40 per dependent for death claim.

4. Weekly Compensation:

- *Indicate Payment Type:*
  - *TI:* Total Incapacity
  - *PI:* Partial Incapacity
  - *DB:* Death Benefits
- *Payment period Date from:* Date of Incapacity (first full day without wages). Do **not** adjust date for three-day waiting period.
- *Payment period Date through:* Last date of the benefit period for which benefits were paid.
- *Number of Weeks & Days:* Number of weeks and days that the payment represents. Three-day waiting period may be deducted here.
- *Total Weekly Rate:* Total weekly compensation rate used.
- *Variable Partial Total Spendable:* Only use when paying 'variable' or 'working' partial. Total amount of Spendable Earnings for the weeks of variable partial as listed in Section 5 of this form. See Calculation of a Variable Partial for more information.
- *Compensation Paid:* Total compensation paid.
- *Settlement/Deny & Dismiss:* Enter amount of settlement or D&D, WC Court Decree number, and date of Decree.

5. Weekly Compensation for Variable Partial Payments:

- *Week Ending:* Week ending date for the Gross Earnings listed.
- *Gross Earnings:* Total weekly gross earnings of claimant.
- *Spendable Base Wage:* Enter appropriate figure from Gross Wage to Spendable Earnings Table. Note: If paying Suitable Alternative Employment (SAE) write 'SAE' in the Spendable Earnings column and complete other columns as noted.
- *Amount Paid:* Amount paid by the claim administrator for that week.

- *Signature/Date*: Signature of the person who filled out the form and the date that the form was prepared.
- *Print Name/RI Adjuster License Number/Phone & Extension:* Clearly enter the name of the person who filled out the form, their RI Adjuster License Number as issued by the RI Department of Business Regulation, and the complete phone number of the preparer. Note: DO NOT ENTER SSN – Request another number from DBR.

State of Rhode Island
MUTUAL AGREEMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

This form may be used pursuant to Rhode Island General Law § 28-35-6(b) to amend a Memorandum of Agreement, Order or Decree regarding a Workers' Compensation claim. This form cannot be used for commencement or termination of weekly benefits.

YOU *MUST* ATTACH A COMPLETED REPORT OF INDEMNITY PAYMENT (DWC-22) TO THIS MUTUAL AGREEMENT.

3. INDICATE THE ACTION(S) OF THIS MUTUAL AGREEMENT:

☐ Change total average weekly wage from $ _____ to $ _____
☐ Change weekly spendable base wage to $ _____ as of _____ (date)
☐ Change weekly compensation rate to $ _____ as of _____ (date)
☐ Change marital status to ☐ Single ☐ Married as of _____ (date)
☐ Change maximum number of exemptions to _____ as of _____ (date)
☐ Change number of dependents to _____ as of _____ (date)
☐ Change nature of injury and/or affected body part to _____
☐ Modify from total to partial incapacity as of _____ (date)
☐ Modify from partial to total incapacity as of _____ (date)
☐ Suitable Alternative Employment (Attach SAE Offer) as of _____ (date)
☐ Other (Specify) _____

_____

_____

DO NOT USE THIS FORM FOR A SPECIFIC INJURY (DISFIGUREMENT, LOSS OF USE, HEARING LOSS); USE THE REPORT OF SPECIFIC PAYMENT (DWC-51).

Employee Signature:	Date:	Employer/Insurer Signature:	Date:

MUTUAL AGREEMENT
(DWC-24)

General Instructions:

- Completed by: Employer/Insurer and Employee.
- Time Frame: No set time frame. Use whenever appropriate.
- Distribution: Original to Department of Labor and Training. Copy to each of the parties.
- Attachments: A completed Report of Indemnity Payment (DWC-22).

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).

3. Indicate the action(s) of this Mutual Agreement:

- Check the appropriate box and enter requested information.
- **Note:** This form is no longer used for disfigurement or loss of use. See the Report of Specific Payment (DWC-51).
- *Employee Signature/Date – Employer/Insurer Signature/Date:* Both parties must sign and date this form.

State of Rhode Island
REPORT OF EARNINGS

Department of Labor and Training, Division of Workers' Compensation
Phone (401) 462-8100 TDD (401) 462-8006

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM ADMINISTRATOR:

FEIN _____
Name _____
Address _____
City, State, Zip _____
Phone _____ Ext. _____

This report covers the time period from: _____ **to:** **PRESENT**

3. NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION:

If you are receiving weekly workers' compensation benefits, YOU MUST REPORT ANY EARNINGS YOU RECEIVE TO THE CLAIM ADMINISTRATOR THAT IS PAYING YOUR BENEFITS. "Earnings" include any cash, wages, or salary received from self-employment or from any employer other than the employer where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (for example: a building custodian receiving a rent-free apartment).

Your endorsement on a benefit check or deposit of the check into an account is your statement that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is a further affirmation that you have made no false claims or statements or concealed any material fact regarding your workers' compensation claim.

You must report any work for any business or person, even if the business or person lost money or if profits or income were reinvested or paid to others. If you performed any duties for any business or person for which you were not paid, you must show a rate of pay of what it would have cost the employer to hire someone to perform the work you did, even if your work was for yourself, a relative, or friend.

You are NOT entitled to workers' compensation benefits for any time you are imprisoned as a result of a criminal conviction.

4. Employee Complete:

1. Did you receive earnings or payments during the above period? State YES or NO: _____
2. Did you perform non-paid work activities during the above period? State YES or NO: _____

If you answered NO to BOTH questions, sign, date and return the form to the CLAIM ADMINISTRATOR above.

If you answered YES to EITHER question, complete the following:

Employer Name _____ Self-Employed? ☐ Yes ☐ No

Address _____ Nature of business _____

City _____ State _____ Zip Code _____ Phone _____

5. Earnings Received:

Report pre-tax earnings. Include any cash, bonus, commission, and the cash value of any payment received in any form other than cash. *Attach additional pages if necessary.*

Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:	Date Earned:	Amount:

Failure to report earnings as defined will subject you to criminal prosecution and civil liability including the suspension or forfeiture of your benefits. This form MUST BE SIGNED, DATED and returned to the Claim Administrator -- EVEN IF YOU HAVE NO EARNINGS.

Employee Signature: _____ Date: _____

Witness Signature: _____ Date: _____

For instructions visit our web site: www.dlt.ri.gov/wc

REPORT OF EARNINGS
(DWC-25)

General Instructions:

- Completed by: Claim Administrator and Employee.
- Time Frame: No set time frame. However, whether fraud is suspected or not, the Report of Earnings should be sent out at the beginning and end of each claim and at reasonable intervals throughout every ongoing claim.
- Distribution: Original from employee to claim administrator. DO NOT SENT TO DLT.
- Attachments: None, unless additional pages were required.

Definitions:

1. Employee Information:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.

2. Claim Administrator or Self-Insured Employer:
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
- *This report cover the time period from/to PRESENT:* After *From*, enter the first day that the employee lost from work due to the injury. (Incapacity date)

3. NOTICE TO EMPLOYEES RECEIVING WORKERS' COMPENSATION: Notice should be read completely.

4. Employee Complete:
- *1. State YES or NO:* When answering the question, the employee must write in either Yes or No.
- *2. State YES or NO:* When answering the question, the employee must write in either Yes or No.
- *Employer Name:* Name of employer providing the earnings, as listed in Section 3.
- *Self-Employed?:* Check appropriate box.
- *Address(including city, state, zip, phone):* Address and telephone number of employer providing the earnings, as listed in Section 3.
- *Nature of Business:* General classification of what the business does on a daily basis. (Ex. Restaurant; Jewelry Manufacturing; etc.)

5. Earning Received:
- *Date Earned/Amount:* Enter the date the earnings were earned and the amount of earnings.
- *Employee Signature/Date:* Signature of employee and date form was signed.
- *Witness Signature/Date:* Signature of witness to employee's signature and date form was signed.

State of Rhode Island
WAGE TRANSCRIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

This form will not be accepted for filing unless all information is completed.

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

3. INSURER COMPLETE:

This wage transcript is submitted to support a:

☐ **Discontinuation of benefits.** The employee has returned to work at a wage equal or greater than he or she earned at the time of the injury.

☐ **Reduction of benefits.** The employee has returned to work at a wage less than he or she earned at the time of the injury.

Date benefits were discontinued or reduced: _____

Pre-injury average weekly wage, **not** including overtime: _____

4. EMPLOYER COMPLETE:

Post-Injury Earning Information -- WEEKS MUST BE CONSECUTIVE

	Period Start Date	Period End Date	Number of Hours Worked	Payment Rate	Amount of Earnings
Week 1					
Week 2					

Employer Name: _____

Address: _____

City, State Zip: _____ Phone: _____

Employer/Insurer Signature: Date:

WAGE TRANSCRIPT
(DWC-30)

General Instructions:

- Completed by: Insurer and employee's return-to-work employer.
- Time Frame: No set time frame. However, if the insurer/employer cannot obtain a Suspension Agreement and Receipt from the employee and he or she has been back to work at least two consecutive weeks equal to or in excess of their average weekly wage, not including overtime, a Wage Transcript can be used to close the claim.
- Distribution: Original to Department of Labor and Training. Copy to employee and/or the employee's legal representative.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).

3. Insurer Complete:

- *Discontinuation of benefits/Reduction of benefits:* Check appropriate box.
- *Date benefits were discontinued or reduced:* Date the employee returned to work.
- *Pre-injury average weekly wage, not including overtime:* Enter average weekly wage that contains the averaged bonus amount, but not overtime.

4. Employer Complete:

- *Post-Injury Earning Information:*
  - *Period Start Date:* Beginning date of the earnings period.
  - *Period End Date:* Ending date of the earnings period.
  - *Number of Hours Worked:* Number of hours worked during the pay period listed.
  - *Payment Rate:* Hourly or salary rate for payment period listed.
  - *Amount of Earnings:* Amount paid for the payment period listed.
- *Employer Name:* Name of actual employer where wages were earned.
- *Address(including city, state, zip, phone):* Address and telephone number of employer where the wages were earned.
- *Employer Signature/Date:* Signature of the employer's Treasurer or other appropriate official and the date prepared.

State of Rhode Island
EMPLOYEE'S OBJECTION TO WAGE TRANSCRIPT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____
Phone _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____
Incapacity date _____

The employee objects to the discontinuance or reduction of workers' compensation benefits pursuant to RIGL Section 28-35-47 and requests a review by the Workers' Compensation Court, pursuant to RIGL Section 28-35-51.

Employee: Date:

EMPLOYEE'S OBJECTION TO WAGE TRANSCRIPT
(DWC-31)

General Instructions:

- Completed by: Employee.
- Time Frame: Employee must file this notice with DLT within two weeks of receipt of Wage Transcript.
- Distribution: Original to Department of Labor and Training. DLT will notify Workers' Compensation Court.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:

- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.

2. Claim Information:

- *Employer:* Employer's actual name where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Employee Signature/Date:* Signature of the employee and the date prepared.

State of Rhode Island
Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 (401) 462-8100 TDD (401) 462-8006

NOTICE TO EMPLOYEES
REGARDING THE EFFECT OF ENDORSEMENT OF BENEFIT CHECK

You are presently receiving or have filed a claim to receive workers' compensation benefits. You should know and are hereby advised that by endorsing your workers' compensation benefit check or upon deposit of your workers' compensation check into an account, you are declaring that you are receiving benefits under the Workers' Compensation Act. In other words, your endorsement on a weekly benefit check is your statement that you are entitled to receive workers' compensation benefits for that week under the Workers' Compensation Act and have made no false claims or statements or concealed any material fact.

Furthermore, if you can return to any work and receive earnings, which includes wages, salary, commissions, bonuses, cash, and/or any other compensation other than money, YOU MUST REPORT THESE EARNINGS TO YOUR EMPLOYER'S CLAIM ADMINISTRATOR IMMEDIATELY. If you endorse a benefit check that is for a week in which you had earnings AND YOU FAIL TO REPORT THESE EARNINGS, YOU MAY BE PROSECUTED BY THE ATTORNEY GENERAL AND SENT TO PRISON.

You are NOT ENTITLED to receive workers' compensation benefits for any time that you are imprisoned as a result of a criminal conviction.

State of Rhode Island
ITEMIZED STATEMENT OF COMPENSATION

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8006

DWC No. _____

Insurer File No. _____

1. EMPLOYEE INFORMATION:

SSN _____
Name _____
Address _____
City, State, Zip _____

2. CLAIM INFORMATION:

Employer _____
Insurance Co. _____
Claim Administrator _____
Injury date _____ Incapacity date _____
Date of death _____ ☐ Work-related OR Not ☐

3. ☐ **Incident Only--**No payments made. Complete Section 8 and return to DLT ***only*** at above address. ***All others continue below.***

4. NONPAYMENT OF WEEKLY INDEMNITY ONLY: Check correct box and complete appropriate information on remainder of form.

☐ **Medical Only*** *Payment info must be listed below ☐ **Federal Jurisdiction** ☐ **Salary Continuation** ☐ **Denied**

Do **NOT** use *Other* if claim is *Denied*

☐ **Death--**Liability established; no dependents. Payment made to WCAF ☐ **Other:**

5. DIAGNOSIS:

Primary Written Diagnosis	ICD Code:
Secondary Written Diagnosis	ICD Code:

6. PAYMENT INFORMATION: (List total amount paid for each appropriate item in both columns) **DATE OF FIRST INDEMNITY PAYMENT:** _____

Temporary Partial		Hospital/Treatment Center	
Temporary Total		Independent Medical Exams	
Permanent Total		Pharmaceutical	
Weekly Death Benefits		Chiropractic	
Burial		Diagnostic Testing	
Specific - Disfigurement		Attorney Fees Awarded by Court	
Specific - Loss of Use		Penalties/Interest	
Vocational Rehabilitation		WC Administrative Fund (WCAF)	
Physical Therapy		Settlement	
Occupational Therapy		Deny & Dismiss	
Psychological Services		Other Payments:	
Physicians		Subrogation ☐ Yes ☐ No	

7. RETURN TO EMPLOYMENT: Did the employee return to employment? ☐ Yes ☐ No ☐ Unknown

If yes, was it with the ☐ same employer OR a ☐ different employer ☐ Unknown Date Returned: ☐ Unknown

8. THIS REPORT WAS PREPARED BY: **PLEASE PRINT**

Name		RI Adjuster License Number
Company Name		
Address		
City	State	Zip Code
Telephone	Extension	Email

Signature _____ Date _____

Distribution: DLT, Division of Workers' Compensation; Employee and Attorney; Employer

ITEMIZED STATEMENT OF COMPENSATION
(DWC-50)

General Instructions:

- Completed by: Claim Administrator.
- Time Frame: Within 60 days after the discontinuance or suspension of compensation payments.
- Distribution: Original to Department of Labor and Training (DLT). Copy to the employee and his or her attorney and also to the employer, if filed by the insurer.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.

1. Employee Information:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.

2. Claim Information:
- *Employer:* Name of company where the employee was employed at the time of the injury.
- *Insurance Co.:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Claim Administrator:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Injury Date:* Date that the accident happened.
- *Incapacity Date:* First full day that the employee lost from work (include weekends and holidays).
- *Date of Death:* Conditional, if employee died – Check appropriate box as to whether death was work-related or not.

3. Incident Only:
- Check this box if no payments were made on the claim. Complete Section 8 and return to DLT only.

4. Nonpayment of Weekly Indemnity Only:
- *Medical Only:* Check if medical payment(s) were made on the claim but NO weekly indemnity.
- *Federal Jurisdiction:* Check if claim fell under Federal Jurisdiction for weekly indemnity.
- *Salary Continuation:* Check if full salary was continued for employee.
- *Denied:* Check if claim was denied by Claim Administrator.
- *Death:* Check if death was work-related and there were no dependents.
- *Other:* Use **only if** none of the above apply; for example, if the claim is under another state's jurisdiction and had been sent to RI by mistake.

5. Diagnosis:
- *Primary Written Diagnosis:* Enter the primary written diagnosis supplied by medical provider.
- *ICD Code:* International (Statistical) Classification of Diseases (and Related Health Problems) code should be supplied by medical provider.
- *Secondary Written Diagnosis:* Enter the secondary written diagnosis, if any, provided by medical provider.
- *ICD Code: International* (Statistical) *Classification of Diseases* (and Related Health Problems) code should be supplied by medical provider.

6.Payment Information: For each and every item where payment was made, enter the total amount paid. In the case of Subrogation, check Yes or No as to whether or not the claim was subrogated.
- *Date of First Indemnity Payment:* Enter the date the first indemnity payment was made.

7. Return to Employment: Please complete all requested information.

8. *This Report was Prepared by:* **PRINT ALL INFORMATION**
- *Name:* Print full name of person who filled out the form (report preparer).
- *RI Adjuster License Number:* Enter RI Adjuster License Number as issued by the RI Department of Business Regulation. Note: DO NOT ENTER SSN – Request another number from DBR.
- *Company Name:* Name of the company where the report preparer is employed.
- *Address (including city, state, zip):* Mailing address of the company where the report preparer is employed.
- *Phone/Ext/Email:* Phone number and extension (if necessary) and email address of the report preparer.
- *Signature/Date*: Signature of the person who filled out the form and the date that the form was prepared.

State of Rhode Island
REPORT OF SPECIFIC PAYMENT

☐ PLEASE CHECK IF CORRECTION OF PRIOR REPORT

Department of Labor and Training, Division of Workers' Compensation
PO Box 20190, Cranston, RI 02920-0942 Phone (401) 462-8100 TDD (401) 462-8084

DWC No. _____

Insurer File No. _____

YOU ***MUST*** CHECK ONE OF THE FOLLOWING:

☐ **LOST TIME** ☐ **NO LOST TIME** ☐ **FEDERAL JURISDICTION**

1. EMPLOYEE:	**2. EMPLOYER:**
SSN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Date of Birth	Phone Ext.
3. INSURANCE COMPANY NAMED ON WC POLICY:	**4. CLAIM ADMINISTRATOR:** ☐ **SAME AS BLOCK 3**
FEIN	FEIN
Name	Name
Address	Address
Address	Address
City, State, Zip	City, State, Zip
Phone Ext.	Phone Ext.
RI License Number	RI License or Self-Insurance Number

5. CLAIM INFORMATION:

Injury date _____ Incapacity date (if appropriate) _____

Average Weekly Wage (including OT) _____ Weekly Specific Rate _____

Specific paid by: ☐ Court Order Date: _____ Number: _____ **OR** ☐ Agreement of the Parties

Description of Injury/Specific: _____

Attorney Fee: _____

6. SPECIFIC PAYMENT INFORMATION:

Indicate Payment Type	Body Part	Percent of Loss	Number of Weeks	Amount Paid	Date Paid
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					
☐ disfigurement ☐ loss of use					

Hearing Loss			Total/Partial Deafness		Number of Weeks	Amount Paid	Date Paid
Left Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			
Right Ear	☐ occupational	☐ traumatic	☐ total	☐ partial			

Employee Signature: Date:	Employer/Insurer Signature: Date:
(Not required for Court Order)	

For instructions visit our web site: www.dlt.state.ri.us/wc

REPORT OF SPECIFIC PAYMENT
(DWC-51)

General Instructions:

- Completed by: Claim Administrator
- Time Frame: The Report of Specific Payment should be filed with the Department of Labor and Training (DLT) within 10 days of payment. Payment must be mailed to claimant within 14 days of the entry of a decree, order, or agreement of the parties.
- Distribution: Original to DLT.
- Attachments: None.

Definitions:

- *PLEASE CHECK IF CORRECTION OF PRIOR REPORT:* Check if sending in an amended form.
- *YOU **MUST** CHECK ONE OF THE FOLLOWING:*
  - *Lost Time:* Check if claimant received any weekly indemnity payments.
  - *No Lost Time:* Check if claimant did not receive any weekly indemnity payments.
  - *Federal Jurisdiction:* Check if claim was paid under Federal jurisdiction.

1. Employee:
- *SSN:* Employee's Social Security Number.
- *Name:* Employee's full name.
- *Address (including city, state, zip):* Employee's current mailing address.
- *Phone:* Employee's current home telephone number.
- *Date of Birth:* Date the employee was born.

2. Employer:
- *FEIN:* Employer's Federal Employer Identification Number.
- *Name:* Employer's actual name where the employee was employed at the time of the injury.
- *Address (including city, state, zip):* Address of the employer's actual location.
- *Phone/Ext:* Phone number and extension (if necessary) of the employer's facility.

3. Insurance company named on WC Policy:
- *FEIN:* WC Insurance company's Federal Employer Identification Number.
- *Name:* Name of the worker's compensation insurer OR 'Self-Insured' if the company has been certified as self-insured by DLT.
- *Address (including city, state, zip):* Mailing address of the WC insurance carrier named on the WC Insurance Policy.
- *Phone/Ext:* Phone number and extension (if necessary) of the named WC insurance carrier.
- *RI License Number:* License number issued by the RI Department of Business Regulation (DBR).

4. Claim Administrator: If this information is identical to the information in Block 3, check the 'Same' box. If different, proceed below.
- *FEIN:* Federal Employer Identification Number of the company administering the claim.
- *Name:* Name of the WC insurance carrier, third party administrator, or self-insured employer responsible for administering the claim.
- *Address (including city, state, zip):* Mailing address of the claim administrator.
- *Phone/Ext:* Phone number and extension (if necessary) of the claim administrator.
- *RI License or Self-Insurance Number:* License number issued by DBR or Self-Insurance Certificate number issued by DLT.

5. Claim Information:
- *Injury date:* Date that the accident happened.
- *Incapacity Date(if appropriate):* First full day that the employee lost from work (include weekends and holidays).
- *Average Weekly Wage (including OT):* Claimant's total average weekly wage.
- *Weekly Specific Rate:* Weekly rate used to pay specific.
- *Specific paid by:*
  - *Pretrial Order or Decree/Date/Number:* Check appropriate box and enter date and Court-assigned number of document.
  - *Agreement of the Parties:* Check if appropriate.
  - *Description of Injury/Specific:* Describe what the specific payment is being made for.

6. Specific Payment Information:
- *Indicate Payment Type/disfigurement or loss of use:* Check appropriate box(es).
- *Body Part:* Enter appropriate part of body.
- *Percent of Loss:* Enter percentage of loss.
- *Number of Weeks:* Enter number of weeks being paid for that entry.
- *Amount Paid:* Total amount paid for that entry.
- *Date Paid:* Enter payment date for that entry.

- *Hearing Loss/ Left/Right Ear-Occupational/Traumatic:* Check appropriate box(es).
- *Total/Partial Deafness:* Check appropriate box(es).
- *Number of Weeks:* Enter number of weeks being paid for that entry.
- *Amount Paid:* Total amount paid for that entry.
- *Date Paid:* Enter payment date for that entry.

- *Employee Signature(Not required for Court Order)/Date:* If the Report has been paid by *Agreement of Parties*, this area is for the claimant to sign and date.
- *Employer/Insurer Signature/Date:* Signature of employer or insurer and date prepared.